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Southwestern MEDICINE

OFFICIAL JOURNAL OF THE SOUTHWESTERN MEDICAL ASSOCIATION AND EL PASO COUNTY MEDICAL SOCIETY

August, 1952

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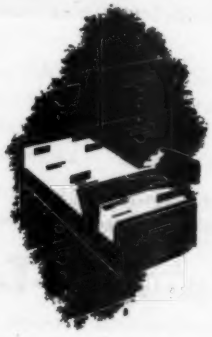
Specialists in information



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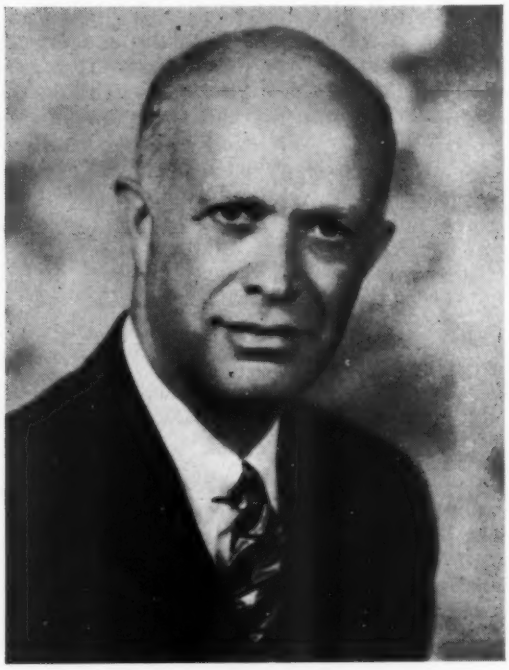
DR. MEYER TO SPEAK ON CANCER AT SOUTHWESTERN CONFERENCE



Dr. Herbert Willy Meyer

Dr. Herbert Willy Meyer, one of the nation's outstanding authorities on cancer, will be on the agenda at the annual meeting of the Southwestern Medical Association in Albuquerque, October 30 through November 1, Dr. Wesley O. Connor, Jr., Albuquerque, president-elect of the association, has announced.

Dr. Meyer, whose papers on cancer, particularly of the breast, are known as classics, has been asked to speak again on this subject. It will be his second appearance at a meeting of the Southwestern Medical Association.

At present Dr. Meyer is professor of clinical surgery at the New York University Post-Graduate Medical School. He is visiting surgeon at Bellevue Hospital, attending surgeon at University Hospital, and associate attending surgeon at Lenox Hill Hospital. He is a governor of the American College of Surgeons, a member of the Societe Internationale de Chirurgie, the American Association for Thoracic Surgery, the American Association for Cancer Research, the New York Surgical Society, the New York Academy of Medicine, the James Ewing Society, the New York State and New York County Medical Societies, and the American Medical Association.

Another speaker on the program, previously announced by Dr. Connor, is Dr. Louis N. Katz prominent in the field of cardiology, who at present is director of Cardiovascular Research and also professorial lecturer in Physiology at the University of Chicago.

TRUSTEES, KNOW THYSELVES*

Do hospital boards of trustees need help? The boards themselves would doubtless be the first to answer that, more than ever before, they do. Their task has never been easy, and the double onslaught of the most rapid medical advances in the history of the world and the upheaval of American economic and social traditions has multiplied hospital problems a hundredfold.

Hospitals have become highly complicated institutions, requiring special equipment, innumerable medical and surgical items and the best that money can buy in furnishings and food supplies. To provide all this is a major financial operation, which has assumed terrifying proportions under the economic conditions of today. Yet this heavy responsibility of hospital boards is secondary to that of seeing that the highest standards of medical and surgical practice are maintained. The trustees are the final authority on professional as well as administrative policies for the hospital. As a general rule, moreover, board members lack any real background of experience for their increasingly complex task. Unlike the directors of business firms, who have usually had extensive experience in their fields, hospital trustees are dependent on the professional and administrative staffs for much if not most of the specialized knowledge upon which decisions must be based.

REGULAR CHECK

More and more, it seems evident that some system for a regular check or "audit" of the work of hospital boards is needed. The work of physicians in hospitals is, very properly, under constant examination. A diagnosis must be made before a patient is admitted. If an operation is performed the pre-operative diagnosis is compared with post-operative findings. A 75 per cent attendance at monthly staff meetings is expected; and case records of patients who have died or developed complications are discussed at these meetings to determine whether any errors were made in judgment or technique, and whether everything possible was done. This vigilance guards against repetition of any errors and allows the staff as a whole to benefit from its members' work.

While the work of the board of trustees does not affect the welfare of patients quite as directly as that of physicians, physicians' tasks may be directly affected by the administrative policies of the hospitals in which they work. Smooth administration and sound financial management create an atmosphere of harmony, from which both patients and physicians can take confidence. If an "auditing" committee, made up perhaps of corporation members with special knowledge of such problems as public relations, employer-employee problems, fund-raising, teaching and research (to mention a few), would regularly analyze board plans and decisions, board members and the hospital as a whole would benefit.

TRUSTEES ANSWERABLE

Trustees should be made answerable for their functions, as physicians are for the care of patients. Trustees should be checked on whether they are receiving sound and unbiased advice in medical matters from truly impartial physicians; on whether they are consulting the staff as a whole through its *elected* representative committee rather than individual physicians who may not be free of prejudice; on whether adequate supervision is being given to the work of the superintendent or medical director; on whether there are lapses in physician-hospital and public relations. Are trustees attending board meetings conscientiously, and are their committees assiduous in performing their assignments? Situations such as those which occurred fairly recently in two Boston hospitals, when the boards of trustees realized the seriousness of their financial condition only when the milkman, butcher and drug houses threatened to stop delivering supplies, can no longer be tolerated. By definition, a trustee is one who holds property in trust, with the implication that he manage it so that its value for its original purpose remains as high as possible.

Hospital management has become a technical specialty requiring skilled direction to keep patients' interests, physicians' professional requirements, and the hospitals' financial resources in proper balance. The work of trustee should be regularly checked, even more carefully than the work of physicians, since physicians are trained for their jobs, and trustees are not.

*Reprinted from Norfolk Medical News.

De Rebus Medicis Et Politicis

BY ROBERT B. HOMAN, JR., M. D., EL PASO, TEXAS
MEMBER OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

YOUR PROBLEMS

One great advantage of attending sessions of the House of Delegates of the A. M. A. is the privilege of associating with the leaders of medicine from the various states and territories. This association is not confined to the delegates and officers of the A. M. A. It includes the Presidents, Presidents-elect, and the medical and the lay secretaries of the constituent medical associations, and other distinguished American doctors. I have often wished that many doctors in this great Southwest could share this privilege with me, for I am sure that such experience would be inspirational to them.

It has been my purpose during these meetings to try to reach an understanding of the problems of medicine — your problems — on a local, state, and national level. I find that the local and state medical problems are the same throughout this great country — the same that we have here in our own area — in varying degrees, of course.

MAJOR PROBLEMS

Aside from the American drift toward socialism, which would include the socialization of medicine, what are the major problems which concern these men who have been elected by their fellow doctors to represent them or to serve them? I shall make no attempt to list them in the order of their importance nor will space permit expanding upon them. In future articles some of these universal problems may be discussed at length.

Doctors throughout the country are talking about the shortage of nurses, the shortage of technicians, and other trained personnel; about adequate distribution of doctors and medical facilities to serve all Americans; about medical education and the threat of federal domination of medical colleges; about the doctor-hospital relationship which in some areas is a major problem; about the Veterans' Administration medical care program, which threatens the private system of medicine; about medical ethics and the problem of discipline of wayward doctors; about the necessity for local medical public relations programs, grievance committees, emergency telephone exchanges; about the doctors' lack of interest in local and state civil defense program; and about the importance of doctors supporting the voluntary hospital and medical care insurance program.

OVERCHARGING

These briefly are some of the topics most often in the conversation of doctors in national convention. However, there is one subject which invariably comes up for discussion whether the conversation is brief or extended. That is the problem of some doctors overcharging for medical and surgical care. It is a sad commentary on our profession that this is a problem so universal in America and that so little is being done about this disgraceful situation. This is a matter which must be controlled at the local level — in the county medical society, and such control is a duty which county societies can no longer ignore.

It is of little avail for us to strive to regain lost public good will if we are too phlegmatic to clean our own house. Our constitution and by-laws give us the instruments through which to do the job; all that is needed is the desire.

CHICKENPOX

Chickenpox And Chloromycetin

Anthony, E., Brit. Med. J. 1:414, 1951

A case report of a 35-year-old man with varicella treated with Chloromycetin. States the author, "In twenty years of general practice I have never seen a more severe case of chickenpox at onset nor such a dramatic recovery."

Clinical Clippings, May, 1951.

PRODUCT INFORMATION

DROMORAN HYDROBROMIDE *(Roche)*

A highly potent synthetic analgesic having properties similar to those of meperidine, morphine and methadon. Its margin of safety is higher than that of methadon and it is considerably more potent and long-acting than morphine. Dromoran is available in 1-cc. ampuls and 10-cc. multiple-dose vials.

Narcotic license required.

APHORISMS

TRUTHS AND CONCEPTS CONCERNING MISCELLANEOUS CONDITIONS

By Andrew M. Babey, M. D., Las Cruces, N. M.

1. "A dilated superior vena cava with little or no enlargement of the heart is highly suggestive of constrictive pericarditis." — V. McKusick, Bulletin Johns Hopkins Hospital, January '52, Page 21.

2. "Physiologically and sometimes roentgenologically, constrictive pericarditis can very closely simulate mitral stenosis. It is clear from the physiologic standpoint it makes no difference whether the left ventricular filling is impeded by narrowing of the mitral orifice or by a decrease in diastolic capacity of the ventricle itself." — V. McKusick, Bulletin John Hopkins Hospital, January '52, Page 22.

3. "Certain features of the disease (mitral stenosis) when present indicate that operation would be forbiddingly hazardous or unsuccessful. These are bacterial endocarditis, active rheumatic disease, obstructive disease of the aortic valve, intractable right heart failure and significant mitral insufficiency." — E. C. Andrus, et al, Bulletin Johns Hopkins Hospital, Feb., '52, Page 175.

4. "Beginning as a disease of a heart valve (mitral stenosis) it becomes a disease of the lung and of the pulmonary circulation which at length overwhelms the strength of the right ventricle. From the standpoint of probable improvement after surgery the key to the problem evidently lies in the lungs: the effect of long standing pulmonary congestion and the presence or the development of concomitant inflammatory reactions involving the pulmonary vasculature and alveolar walls. The tests applied to determine the presence of "active" rheumatic disease in the heart have not proved adequate in all cases." — E. C. Andrus, loc.cit.

5. "It is logical to assume that typical murmurs appear earlier than any changes in the external contour of the heart and that definite clinical mitral stenosis may be present without any demonstrable roentgenographic changes." — N. Cooley, Bulletin Johns Hopkins Hospital, Feb., '52, Page 177.

6. " . . . the triad of anemia, albumenuria and hyperglobulinemia is by far the most important clue in the laboratory diagnosis of multiple myeloma and this combination should immediately suggest bone marrow aspiration for histologic confirmation." — W. Kraus, Med. Grand Rounds, M. G. H., American Practitioner, Dec., 1951, Page 1062.

7. "The demonstration of Bence-Jones protein in the urine has become a procedure of almost purely academic interest today." loc cit, Page 1062.

8. "Lesions in the small bones of the hands and feet were not seen in any of (our) cases (of myeloma)." loc cit, Page 1063.

9. "We know that diseases characterized by hyperglobulinemia are diseases that are apt to have a high incidence of amyloid. This is what you see in rheumatoid arthritis where there is about 20 per cent instance of amyloid disease, and where there is also a hyperglobulinemia." — W. Bauer, loc cit, Page 1063.

10. " . . . the amyloid usually associated with myeloma is supposedly the "primary" or atypical amyloid and in that condition the Congo red test is very often negative." — B. Castleman, loc cit, Page 1064.

11. "Primary carcinoma of the thyroid gland should be considered in the presence of tumors of the side of the neck even in the absence of palpable nodules in the gland itself." — H. H. Searls, et al, California Medicine, Feb., '52, Page 62.

12. "If one is doing a physical examination he must always look at the soles of the feet and always feel the testicles. Then one is not apt to miss a melanoma or one of those very malignant tumors of the testicle." — Walter Bauer, Am. Practitioner, Jan., '52. Page 58.

13. "For several years now, I have been advising anyone who would listen to me that it is dangerous to do a sternal puncture in a person who has a bleeding tendency such as thrombopenia . . . . In people over 60 the spinous process marrow tends to be fibrosed and dry and results are disappointing. Iliac marrow aspiration is technically the most difficult. In older people the bone becomes eburnated and I've seen the needle actually bend during an attempted tap . . . . I prefer no guard, just a plain 19 gauge needle — and

(Continued on Page 295)

ORTHOPAEDIC PROBLEMS IN CHILDREN*

By Louis W. Breck, M. D., El Paso

It will be obvious to all of you that a subject so comprehensive in its scope as the one I am going to discuss can only be partially covered in a short period of time. For this reason I am going to discuss some subjects which I think will be of the most practical value for one thing and another group of subjects which I think may have changed sufficiently recently to merit bringing new aspects of treatment to your attention.

Club feet are essentially divided into two great groups, the regular severe club feet (Talipes equinovarus) and the reverse club feet in which the feet are turned in the opposite direction. The regular severe club feet are those which I will discuss first. In these cases the feet are turned inward and there is a short heel cord which tends to become shorter and tighter rather than loosen up unless treatment is very intensive. The prognosis in this type of club foot is very poor unless treatment is carried out. Treatment should be started as early as possible, preferably between two and four weeks of age.

If it seems more desirable a general practitioner or surgeon may start treatment with corrective casts applying one or two sets of these and leaving them on approximately two weeks. Following this the patient should be sent to the orthopaedic surgeon as the overall prognosis in these cases is not too good and the more adequate the treatment is, the better the end result will be. The usual treatment rendered by us is corrective casts for a period of time, this period varying with the degree of the deformity and the response to treatment. In addition to this a night splint of the modified Dennis-Brown type, which consists of corrective shoes applied to a crossbar is used.

RESISTANT CLUB FOOT

There is a certain type of regular club foot which is referred to as a resistant club foot. In these, the minute treatment is stopped severe recurrence occurs. Some recurrence will occur in any club foot when treatment is stopped however. The real criterion for these resistant cases is the fact that long hard treatment will bring only a fair result and that the foot is very difficult to correct.

One thing that has come about more recently in the treatment of club feet is that in children past the infant stage a great deal of good can be accomplished by transplanting the tibialis anterior tendon laterally on the foot. This is not a very severe operation. Usually a tendon lengthening operation is done at the same time. The key note of treatment in club feet in general is the use of casts and night splints. The most important single phase of the treatment of a case is to impress on the parents the importance of not letting the case fall by the wayside and a recurrence develop. Club foot cases frequently exhaust the patience of the parents and they discontinue treatment and a reccurrence occurs which is difficult to treat.

The so-called reverse club feet do not present a major problem. Usually these cases can be treated by the general practitioner or surgeon at home and all that is needed is one or perhaps two corrective casts. These children are the ones who are born with their foot turned up and out. The cast should be applied in the corrected position with a reasonable amount of force applied to the foot. A below the knee cast is adequate and the only precaution that has to be taken is to avoid making enough pressure to injure the skin or circulation. Following the cast treatment the mother should be instructed to manipulate the child slowly and forcibly into the corrected position fifteen times twice a day for one to three months depending on how the feet look. Frequently when these children begin to walk it is noticed that their feet are quite flat and in these a longitudinal arch support is required. It is interesting to note that the reverse club feet are almost always unilateral.

The subject of flat feet is one which is somewhat controversial as far as the length of time in which treatment should be persisted in is concerned. In general, treatment should be persisted in either until the deformity is corrected or until it is elected to let the case go as it is. This latter situation rarely comes up.

There are many ways to classify flat feet but one of my own which is a simple and practical one seems the best for a general discussion of the subject. They may be divided into (1) simple infantile flat foot, (2) ordinary congenital flat foot, (3) severe resistant flat foot, and (4) spastic flat foot.

INFANTILE FLAT FOOT

The simple infantile flat foot is the one which is a natural condition in many infants.

*Delivered At The Regular Monthly Meeting Of The Lea County Medical Society — Hobbs, New Mexico on September 13, 1951.

They are simply born flat footed and during the first 18 months of life gradually develop a satisfactory longitudinal arch. These cases are the ones which correct spontaneously usually and if not, respond immediately to the use of longitudinal arch supports.

Ordinary congenital flat foot is one which is usually due to heredity and which is fairly amenable to treatment. Treatment should be instituted when the child begins to walk and should be persisted in at least till the age of six. Sometimes it is necessary to keep shoe corrections in these childrens shoes indefinitely because of the prompt tendency to recurrence when they are discontinued. The shoe corrections recommended are longitudinal supports plus a three-sixteenths inner elevation of the heels. Ordinary shoes may be used and either high tops or low tops are satisfactory. Frequently we give these patients foot exercises when they are four to five years old.

The severe resistant club feet are those which promptly recur to a very severe degree the minute treatment is stopped. It is necessary to keep these children in shoe corrections all their lives and frequently a very heavy type of shoe must be resorted to with a very heavy support in it. A number of shoes are available for this purpose but the strongest and most efficient of all of them is the one which is sold under the trade name of "Health Spot" shoes. These do not require additional shoe corrections and have an extremely heavy shank and arch counter in them.

The spastic flat feet are the worse of all and are due to either a congenital anomaly, an arthritis of the foot, or an old severe uncorrected resistant flat foot. After a spastic flat foot is well developed and well formed it constitutes a very difficult problem as to treatment.

I have not mentioned the subject of operating flat feet but it is possible in selected cases to treat these patients surgically with good results.

Knock knees may in some instances be entirely congenital hereditary but this is not usually the case. They are usually due to a combination of a mild ricketts plus flat feet. Sub-clinical ricketts is a condition in which the patient does not have frank ricketts with all the classical signs and in fact such cases of gross ricketts are very rare in the practice of most of us. However, occasionally children are seen in whom the absorption of vitamin D is not normal and in these children a mild case of ricketts develops. Mild but characteristic x-ray changes are seen. Treatment of the ricketts itself is by means of a very large amount of vitamin D for a long period of time. At least ten to twenty times a normal amount of vitamin D is necessary in these children.

The treatment of the flat feet which accompanies the knock knees is that usually used for ordinary flat feet with longitudinal arch supports and inner elevation of the heels.

PROGRESS TRACINGS

The progress of the patient may be measured very easily by making tracings of the knees with the toes pointed straight up. These tracings should include the entire length of both extremities and may be made on a piece of ordinary wrapping paper and kept. Persistence in treatment is the most important thing in these cases as it usually takes from one to six years to get an adequate correction of the deformity and it may even take longer. When the sub-clinical ricketts has cleared up the shoe corrections should be persisted in. In our practice we use braces only rarely as they are seldom indicated. We use wedged casts occasionally for the correction of the deformity but here again they are used much less frequently than one would think necessary. The operative treatment of knock knees is fairly satisfactory but is reserved for older children with a persistant deformity.

The osteochondritities of the growth centers are an interesting subject and one of some considerable importance. The most common of these are Osgood-Schlatter's disease of the knee, osteochondritis of the spine, and Perthes' disease which is the osteochondritis of the hip.

In discussing these conditions in general it is of interest to note that the ideology of them is unknown. It may be that they are from an injury and the injury may or may not be associated with endocrine glandular disturbance probably a disturbance of the thyroid gland. Treatment of these cases consists of rest, the administration of calcium and vitamins by mouth, and the use of thyroid extract in at least some of the cases where it appears to be that there is definitely a thyroid deficiency.

The first one of these which I am going to discuss is Perthes' disease of the hip. This usually begins in early childhood and runs a spontaneous course of one to four years. During this period of time rest of the hip joint must be maintained. How this is maintained is somewhat variable. The best thing to do is to put the child in a hip spica cast for three months to put the hip in complete rest first. Following this the child may be allowed to walk on crutches with complete restriction of weight bearing. One of the ways of accomplishing this restriction of

weight bearing is to bend the knee at a right angle and put a cast on the patient in this position. Another method is by means of a walking Caliper brace. First one method and then the other may be used to keep the child off the hip.

PROGNOSIS

The prognosis in these cases depends on adequate treatment and upon getting as round a femoral head as possible. Surgical treatment is at the present time for the most part rarely used as it has been found that it does not help the end result.

Osgood-Schlatter's disease of the knee is that condition in which there is fragmentation irregularity and pain of the tibial tuberosity where the patellar tendon attaches to the front of the superior portion of the tibia. Our routine method of treating these is to apply a cast for six weeks to put the involved area at complete rest. Following that great care is taken to instruct the patient and his parents in protection of this painful area by means of a piece of felt properly applied. In cases where a good result is not obtained in this way the patient may either be allowed to go longer with restriction of activity or a bone drilling operation in which numerous drill holes are placed through the tibial tuberosity and into the underlying tibia may be done. It must be borne in mind that this condition is not serious as far as producing permanent lasting damage is concerned and is primarily symptomatic rather than crippling.

Vertebral epiphysitis is an inflammation of the vertebrae which occurs in adolescence and which leads to the production of an adolescent round back. The most important thing in the treatment of these patients is for them to sleep in hyperextension on a bent Bradford frame made of pipe and covered with canvas for a period of one to five years until the disease has been arrested and bony maturity attained or nearly attained. These children learn quickly to sleep on this hyperextension frame and it is the most important thing in their treatment. Sometimes a Taylor brace is employed but if so, it is only used for a short period of time.

POLIOMYELITIS

We now come to the subject of poliomyelitis and needless to say it would take a long time to cover the subject at all adequately and I simply want to make a few points in connection with the treatment of this disease. Treatment during the acute stage consists essentially of things that we have been using for some years now. There is nothing new that is of real value although suggestions are constantly being made and tried out. The subject of the use of hot packs is still a very controversial one and we employ them once to several times daily during the period of acute pain and muscle spasm. The use of the respirator or iron lung must be mentioned as it saves the life of an occasional patient. Good supportive treatment is still the most important thing in these cases. Some men at this time are recommending the use of transfusions or pure human plasma as they feel that both of these contain antibodies which may be helpful in combating the disease.

The latter treatment consists of physical therapy for rehabilitation, the careful prevention of deformities by physical therapy, night splints, and braces, the avoidance of the use of casts, and the use of surgical operations later for improving the patient's function.

OSTEOMYELITIS

Osteomyelitis is a most interesting subject in which to observe a complete reversal of treatment, morbidity, and mortality since the advent of first the chemo-therapeutic and more recently the antibiotic agencies. Actually acute hematogenous osteomyelitis is now a disease for the general practitioner or pediatrician rather than for the surgeon or orthopaedist in most cases. Penicillin is the drug of choice and should be given in large doses and for a long period of time. A long period of time in this instance is from one to three months in many cases. One important point in the treatment of osteomyelitis is the early diagnosis of the case so that antibiotic therapy may begin before a large amount of damage has been done to the patient's bone.

The surgical treatment of osteomyelitis consists essentially of draining an abscess in an occasional case, doing an occasional sequestrectomy in a patient who has had considerable bone destruction and in old cases doing an operation for a recurrence or for persistent drainage. It is very surprising how few cases of osteomyelitis in children come to any type of surgery anymore.

SUMMARY

A number of orthopaedic conditions have been presented which are of importance either from the frequency with which they are encountered, the difficulty they may present in diagnosis and treatment, or because newer methods of treatment have been developed in the last few years.

The following conditions were discussed: Club feet, flat feet, knock knees, osteochondritis of several of the growth centers, poliomyelitis, and osteomyelitis.

The President's Column

By Dr. James S. Walsh, Douglas, Arizona
President, Southwestern Medical Association

The 101st annual session of the American Medical Association, held in Chicago in June, measured up to its anticipated greatness. It was my good fortune to have been one of the 1,200 physicians who, along with 13,000 registered guests, witnessed the largest medical meeting in the world.

The vastness of this annual meeting is almost unbelievable and every physician owes it to himself at sometime to attend. More than 400 scientific papers were presented. Technical and medical exhibits numbering 675 were strung out in four double lanes, each more than a quarter of a mile long. There were a number of sound color movies in continuous showing, surgical demonstrations from the operating rooms of the Chicago hospitals were brought directly to the convention by television. For the first time special telecasts originating directly from the A. M. A. sessions were sent coast to coast over N. B. C. It is estimated that thirty million Americans watched each of these programs. No wonder that this annual meeting has become known as "The Worlds Fair of Medicine."

Every doctor attending must have felt intense pride in being a part of American medicine. He must also have felt humble in the presence of such enormous evidence of painstaking care and personal sacrifice by others of his profession in preparing and presenting such a program. His only disappointment could have been his inability to be in half a dozen places at once.

A cheering note was sounded by the coordinating committee of the A. M. A., which has supervised the anti-socialization activities of the National Education campaign since its creation in 1948. The committee reported that its mission may be accomplished by the end of 1952 and requested its disolution at that time. Whitaker and Baxter, the public relation firm which has directed the National Education campaign, also have requested that they be relieved of their responsibilities at that time. They reported that "successful results have far exceeded all our hopes and expectations of 1948 and 1949" and that "there is little likelihood the present congress would enact any compulsory health insurance measure."

I sincerely hope that we are not being over-confident because I am afraid that this is a battle we will have to win many times, but one that we can lose only once.

SURGERY

Aureomycin As An Aid In Abdominal Surgery

Wright, L. T. & Prigot, A., Ann. Surg. 133:364, 1951

Aureomycin is of definite value in treatment and prevention of peritonitis and should be given special consideration in biliary tract surgery. When aureomycin was given intravenously, 15 per cent of patients developed occlusive phlebitis of the arm vein. The incidence of phlebitis seemed to be reduced when aureomycin hydrochloride was employed with sodium glycinate.

Harlem Hosp.

Clinical Clippings, May, 1951.

CARDIAC DISEASE

Khellin In The Treatment Of Angina Pectoris

Osher, H. L., et al., New England J. M. 244:315, 1951

Twenty-six of 33 patients with well established angina pectoris responded satisfactorily to oral administration of 40 mg. khellin* four time daily. Response was evidenced by decrease in frequency and severity of anginal pain, decrease in nitroglycerine requirements and increase in exercise tolerance.

**Eskel, supplied by Smith, Kline and French Labs.*

Boston U.

Clinical Clippings, May, 1951.

AMEBIASIS

A REPORT OF 100 CASES*

By J. G. Rodarte, M. D. and J. D. Ibarra, Jr., M. D., Temple, Texas

At the present time, there is great interest and discussion concerning amebiasis because of the following:

1. There are many controversial and conflicting reports in the literature, particularly in regard to incidence.

2. The return of great numbers of our troops from overseas duty makes this disease of vast importance from a public health standpoint.

3. Great therapeutic advances have been made during the last several years.

The object of this paper is chiefly to present a survey of amebiasis in private patients seen in clinic practice. This gives us a cross-section of patients mostly from the Southwestern and Southern states, and from Mexico.

Amebiasis means the invasion of the tissue of man by Endamoeba histolytica, the primary invasion always occurring through the mucous membranes of the intestines. Since amebiasis may affect every part of the body; it, therefore, makes it very difficult and almost impossible to separate the cases into groups according to their clinical manifestations.

Amoebic infection can no longer be considered as being limited to the intestinal tract and liver. The clinical manifestations are protean.[1] D'Antoni,[7] in his review of the literature, makes clear at least three facts: (1). Amoebic disease has been found in all portions of the gastro-intestinal tract, including the gums and the mouth, the liver, and the biliary tract. It has also been found in the heart, the genito-urinary system, all parts of the thorax, the spleen, the muscles, the nervous system, the eye, and the brain. Manifestations are frequently multiple. (2). Amebiasis can produce almost every conceivable single symptom, as well as many syndromes. Among these are: neuropsychiatric symptoms, ameboma, hemorrhagic intestinal manifestations, intestinal obstruction, intestinal perforation, jaundice, false angina, a pellagra-like syndrome, a pseudocarcinomatous syndrome, a pseudotuberculous syndrome, and many others. (3). Amebiasis frequently appears combined with other conditions. Case reports concern its association with peptic ulcer (ruptured and unruptured), pregnancy and the puerperium abscess, typhoid, paratyphoid, blackwater fever, suprarenal insufficiency, and phlebitis, as well as balantidiasis, lambliasis, and bacillary dysentery.

*From the Department of Medicine of the Scott and White Clinic.

SUMMARY OF CASES

It is not the object of this paper to discuss the epidemiology, pathogenesis, or symptomatology of amebiasis, but to present a summary of 100 cases of amebiasis seen in the Scott and White Clinic. In all instances, the diagnosis of amebiasis was based upon the microscopic identification of either the trophozoite or the cysts of Endamoeba histolytica. Wherever possible, fresh liquid stools following a saline purge were examined. When such specimens were not available, formed stools using eosin-iodine wet preparations were examined for cysts. Whenever there was doubt as to the identity of amoebae, smears fixed in Schaudinn's fluid and stained by an iron-hematoxylin method were employed. Material secured by proctoscopy was examined in the fresh state; and, occasionally, also in fixed, stained preparations.

Even after reading the available literature on amebiasis, it is impossible to determine the true incidence of amebiasis in the United States.[3,4,5,6,8,9,11] Although it is a reportable disease in the majority of the states, the records of city and state departments of health are very inadequate. Table 1 represents the incidence of amebiasis reported by percentage in the recent literature.

Table 1

INCIDENCE OF AMEBIASIS

PHILIPPINE ISLANDS	
Military Personnel	5.5%
Civilian Population	27.0%
UNITED STATES	
1,273 Soldiers confined to U. S.	10.0%
2,727 Soldiers with Overseas Duty	16.3%
296 Dispensary Patients in Chicago	11.8%
Pennsylvania	4.1%
New York	9.7%
Tennessee	11.4%
Louisiana	14.0%
New Mexico	14.8%

The United States Army Manual of Tropical Medicine,[10] states that the incidence of amebiasis is determined by the level of the sanitation existing in the particular area, varying from an average of 9.8 per cent in the United States to 50 per cent or even higher in some regions in the tropics and subtropics. Craig,[5,6] years ago, made the "very conservative estimate" that between 5 and 10 per cent of the population of the United States was infected with E. hystolytica. Faust,[6] in 1942, estimated that with the improved methods of examination, the general United States incidence of amebiasis might well be over 20 per cent; while in the Western Hemisphere, particularly in areas with poor sanitation and moist tropical regions, an incidence of 50 to 95 per cent might be "possibly a reasonable estimate."

In order to obtain 100 consecutive cases of amebiasis, it was necessary to review 6,841 records of patients that had stool examinations. Even though the 6,841 patients gave a history suggestive of parasitic infestation, there were only 1,112 patients with positive stools for parasites. In a number of instances, it was necessary to examine several stools before a positive one was obtained.

The incidence of amebiasis in our series of 6,841 patients is 1.46 per cent. Our very low incidence of amebiasis is probably due to the fact that the patients are private clinic patients having high sanitary living conditions. It is conceivable also that this very low incidence is due to the fact that many of the patients had already had treatment for amebiasis before they reported to the clinic.

Of the remaining 6,741 patients who had stool examinations for parasitic diseases, there were 1,012 instances in which parasites, other than E. histolytica, were found. Most of these other parasites were considered to be non-pathogenic, such as: E. coli, E. hominis, E. nana, E. butschlii, Dientamoeba fragilis, Chilomastix mesnili, and Trichomonas hominis. Giardia lamblia was also found and in some cases was considered mildly pathogenic.

Also, the following Helminths were found: Ascaris lumbricoides, Strongyloides stercoralis, Trichocephalus trichiurus, Necator americanus, Enterobius vermicularis, Hymenolepsis nana, Taenia solium, and Taenia saginata.

In the 100 stools positive for E. histolytica, we found 73 with trophozoites, 25 with cysts, and 2 stools with both cysts and amoeba. The proctosigmoidoscopic examinations revealed amoebic ulcerations in 41 patients. From these 41 patients, material was obtained during proctoscopy and examined microscopically. Thirty-seven of the fresh scrapings revealed trophozoites, and 4 revealed cysts.

Roentgen examinations were done in 55 instances. Only in 17 patients were there any suggestive evidences of E. histolytica disease.

The sex and age incidence of our survey is more or less in accordance with that of other investigators.

Table 2

Ages	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	Total
No. of Cases	6	7	10	36	15	21	4	1	100

There were 78 males and 22 females. The youngest patient was 2 years old, and the oldest 71 years old. The largest group, 36 patients, was in the fourth decade.

The symptomatology of amebiasis is so variable that a full detailed discussion is almost impossible and is not feasible at this time. Table 3 shows a condensation of the "chief complaints."

Table 3

Percentage	0	10	20	30	40	50	60	70	80	90	100
Diarrhea						51					
Abdominal pain and cramps					32						
Flatulence				23							
Weight loss, weakness and anorxia			15								
Intermittent diarrhea and conspitation			13								
Blood in stools		6									
Fever		6									
Backache		5									
Chronic nausea		3									
Headaches		1									
Hemorrhoids		1									
Urticaria		1									
Vertigo		1									
Ano-rectal fistula		1									
Pain in chest		1									

The blood counts merit mention only because of the negative findings. We found no instance of leucocytosis worthy of discussion. Likewise, eosenophillia above 2 or 3 per cent was not encountered. We did not find a single patient with anemia of less than

3,500,000, and the lowest hemoglobin was 8.5 grams (57%).

The newer concepts of treatment may be summarized as follows:

I. Intestinal amebiasis

A. **Aureomycin**[12,18,21] and **Terramycin**[13] have been used by some investigators reporting many series of cases with adequate follow-up data. They claim 100 per cent cure with the use of these drugs. The usual dosage of these antibiotics is 500 mg. every six hours for 7 to 10 days. These two drugs are the most promising at the present time. **Chloromycetin** has not given satisfactory results.

B. **Bismuth Glycolylarsanilate** (Winthrop's Milibis)[11,19] is also being used with good results. The dosage employed is 0.5 gram three times a day for seven days. With one course of this treatment 90 per cent cure can be expected. If necessary, the course can be repeated after one or two weeks.

C. A combination of **Atabrine** with **Carbarsone** has been advocated by Radke.[14] He recommended 0.1 gram of Atabrine four times a day for 15 days, and Carbarsone 0.25 gram three times a day for 10 days. Both of these drugs should be given concurrently. As many as 89 per cent were cured with this plan of treatment.

D. The **Oxyquinoline** derivatives are still used, but have proved to be more successful when used in combination with other amebacides. The plan of treatment with the oxyquinoline drugs that we used for many years prior to the rise of the newer drugs consisted of a combined treatment of Carbarsone[2,20,22] with Diodoquin or Vioform. This treatment consists of 0.25 gram of Carbarsone three times daily for 10 days. The following 10 days, either Vioform 0.5 gram three times a day or Diodoquin 0.6 gram three times a day should be given. Ellenbery, Peyton, Gilmore and Klein,[17] in their many cases studied, found Vioform was superior to the other oxyquinolines.

II. Hepatic amebiasis

A. In amebic hepatitis, **Chloroquine** (Aralen)[15,16] has proved to be the drug of choice. During the first two days, one gram of the drug is given daily, then 0.5 gram daily for two to three weeks. One of the drugs effective in intestinal amebiasis should be given concurrently with Chloraquine. In patients with definite hepatic abscess, surgical drainage is indicated.

SUMMARY AND CONCLUSIONS

1. The incidence of amebiasis in a private clinic has been established.
2. Our very low incidence of amebiasis is not in accord with the incidence found elsewhere.
3. Our findings as to sex and age incidence are in accordance with the percentages reported elsewhere.
4. The multiplicity of symptoms is noted and tabulated.
5. The high percentage of positive findings from proctoscopic examinations is emphasized.
6. An outline of treatment of the more common and usually accepted methods is given.

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A NEW THEORY ON THE FUNCTIONS OF THE THYMUS GLAND AND ITS IMPORTANCE IN THE GENERAL DEFENSE MECHANISM OF THE HUMAN BODY

By Manuel D. Hornedo, M. D., El Paso

EDITOR'S NOTE: *Editors have been subjected to severe criticism by well-meaning writers who have papers expounding pet theories. While theories represent thought and labor, they must be considered simply theories, and even a theory should be based upon accredited experimentation. Your Editor in publishing this particular paper concerning the theory regarding the function of the thymus gland does not accept any responsibility for its accuracy. The idea is unique, and there can be no doubt of the writer's sincerity and for this reason the Editor is deviating from the usual procedure in publishing this highly theoretical article.*

INTRODUCTION:

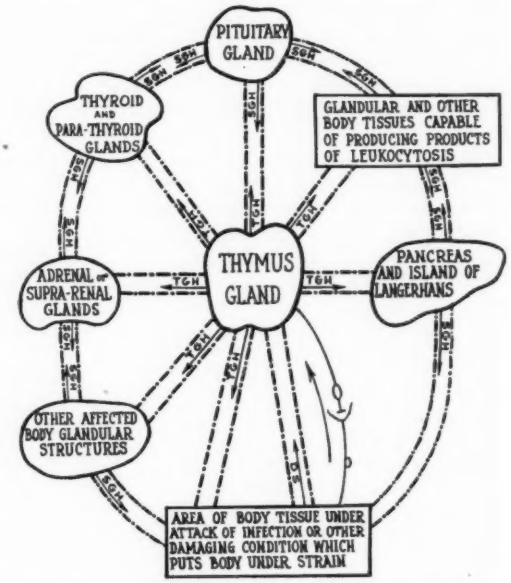
With the discovery of the new functions of the pituitary (hormone ACTH) and the adrenal (hormone CORTISONE) glands, a new concept in regard to the body's general defense mechanism was created. Now that we have used the two hormones in question, we have come to regard their action as only one phase in the complicated phenomenon of the general defense mechanism of the human body to stress or disease. Furthermore, we have found out that the use of excessive amounts of ACTH and CORTISONE may be accompanied by severe reactions, if the dosage is not regulated or stopped in time. Thus the question arises — what glandular structure in the human body really controls the defensive forces during an emergency, such as disease? What gland initiates the phenomenon of leukocytosis, and then checks or stops it, when the emergency is over? Perhaps a more intensive investigation of the real functions of the thymus gland by our research laboratories will some day give us the needed information.

In the past, many theories and interpretations of the functions of the thymus gland have been offered. I realize that the reader may regard this theory as too far-fetched or radical, with insufficient evidence to support it, but nevertheless, I wish to propose it and let it stand or fall on its merits.

THE PROPOSED NEW THEORY

The thymus gland should be regarded as the real regulator or main defense factor in the over-all defense mechanism of the human body.

In the embryo and the young child its size is comparatively large and its functions are very complex and of extreme importance. Its steroid and other hormones probably act either directly or indirectly as trigger hormones or precursors of other gland hormones. This action on the hormone production of other glands, leads to the establishment of a conditioned reflex, which is brought into play whenever the body runs into an attack of infection or other strain. In time, as the individual grows older, this conditioned reflex becomes fixed and almost automatic, needing very small amounts of thymus hormones to set it off; and in consequence due


PITUITARY GLAND
THYROID AND PARA-THYROID GLANDS
GLANDULAR AND OTHER BODY TISSUES CAPABLE OF PRODUCING PRODUCTS OF LEUKOCYTOSIS
ADRENAL or SUPRA-RENAL GLANDS
THYMUS GLAND
PANCREAS AND ISLAND OF LANGERHANS
OTHER AFFECTED BODY GLANDULAR STRUCTURES
AREA OF BODY TISSUE UNDER ATTACK OF INFECTION OR OTHER DAMAGING CONDITION WHICH PUTS BODY UNDER STRAIN
SGH
TGH
DS

Graph: Functions of the Thymus Gland (Theoretical)

· — · — *Blood Stream And Its Auxiliaries*

(INS) ◄—— *Indirect Nervous Stimulation Through Brain and Its Auxiliary Tissues*

TGH *Thymus Gland Hormones Into* ——► *Blood Stream*

(DS) ◄—— *Direct Stimulation By Chemical Products Thrown Out By Damaged Tissue Cells*

SGH *Special Gland Hormones Into* ——► *Blood Stream*

to the reduced production of needed hormones, the gland gradually decreases in size until it becomes vestigial in the adult.

Early exhaustion, or pre-mature atrophy or degeneration of hormone producing portions of the thymus gland, may lead to the loss of output of trigger and other hormones, with consequent failure to bring about the needed reflex action, with the result that infections or other pathological conditions, perhaps including some malignancies such as leukemia, are allowed to establish themselves in the body.

On the other hand, a persistant or hyperthrophied thymus gland, when stimulated by a sudden attack of infection or other severe strain on the body, may produce an overwhelming supply of trigger hormones, leading to shock and death of the patient.

COMMENT

Some European investigators have come to the conclusion that independent parts of the thymus gland produce at least two hormones: (1) a water-soluble, or growth hormone, and (2) a lipoid hormone which produces several effects. The growth hormone is the chief sustaining factor during the growth period, which is the most extended period of stress that the human body has to pass through. The lipoid hormone has been found to produce leukocytosis, even when injected in very small amounts. It is not clear, however, whether another hormone is produced to check the process of leukocytosis once the emergency is over. Also the lipoid hormone has been found to reduce glycogen in the tissues, resulting in an increase of the blood sugar. This reduction of glycogen in the heart muscle, may be so fast as to stop the heart and produce sudden death.

In our country some good work has been done in determining the connection between the thyroid, the pituitary, the adrenal, and the thymus glands; and the effect of the thymus on the development of the sex glands. Recently the thymus gland has been implicated in mouse leukemia, "probably as a bridge between the leukemia stimulus and the disease." When the thymus gland was totally removed in certain strains of mice, leukemia was prevented in most of the animals.

There is also the possibility that the apparent rejuvenation in health of a pregnant woman, during the second half of the period of gestation, may be due to the great hormone producing activity of the thymus gland of the embryo.

AUTHOR'S CONCLUSIONS

1. The thymus gland should be regarded as a very important factor in the general defense mechanism of the human body.

2. The thymus gland seems to be implicated in the chain of factors responsible for leukemia.

3. There is a need for more intensive research work on the function of the thymus gland in health and disease.

SUMMARY

1. The author has advanced a new theory concerning the function of the thymus gland, that is as yet unproved but has some corroboration in the research done by others.

2. The author's theory is that the thymus gland should be regarded as the real regulator or main defense factor in the over all defense mechanism of the human body.

3. A diagram is presented which shows the inter-relationship of the various factors involved.

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DIGITALIS

Chemical Correlations Of Digitalis Potency In Man, Cat and Pigeon

Sciarini, L. J. & Salter, W. T., J. Pharm. Exper. Therap. 101:167, 1951

Considerable agreement was found between chemical assays of U. S. P. Tincture Digitalis for digitoxin and oral assays made in man by Dr. Gold. It is believed that since the digitoxin content of digitalis leaves varies, the commonly employed method of assay based on the intravenous lethal dose in animals is a poor index of oral potency in man.

Yale U. Med. School

Clinical Clippings, May, 1951.

ARMY MEDICAL SERVICE CELEBRATED 177th ANNIVERSARY ON JULY 27

The Army Medical Service celebrated its 177th anniversary on Sunday, July 27, 1952, proud in the knowledge that the combined efforts of its 90,000 physicians, nurses, medical specialists and enlisted men and women have created the healthiest combat force in history.

From the tiny band of doctors and assistants organized as a medical department by the Continental Congress in 1775 at the behest of General George Washington, the Army Medical Service has grown to the largest military medical service in existence. Its members are spread from Pusan to Puerto Rico and from Trieste to Fort Churchill, Canada. Whether in combat or out, Army medical personnel are dedicated to the task of safeguarding and restoring the health of the individual soldier as the best means of conserving America's fighting strength.

PASSING NOTE

Most Army doctors, dentists, medical administrators, nurses and other members of the Army's medical team will be too busy on the 27th to take more than passing note of the anniversary of their organization. They will be so engaged in surgery, X-ray therapy, research, teaching, supply administration or one of a myriad other activities that they will have no time for lavish celebrations.

The extraordinary success of their efforts in Korea and elsewhere is manifest. For one thing, fewer wounded men are dying once they reach treatment than ever before. After that more of them are returning to full duty faster than ever before in the history of warfare. Figures bear out the story. Since last year's anniversary the number of men who survive after getting medical treatment of even the most rudimentary sort has risen from 975 to 977. Both figures contrast strikingly with the 955 per thousand rate of World War II (thought to be unbeatable at the time) and the 915 per thousand ratio of World War I.

NO RESPITE

But the Army's "medics" are not complacent. The tactical battleline may have been stabilized in Korea but there can be no respite in the war on disease, injury and infection. The Army Medical Service must wage an unrelenting offensive lest it lose the battle to its hosts of unseen enemies.

In treatment, research and prevention of disease, the past year has been outstanding for new developments. One of the most significant of these was primaquine, the powerful new drug that promises to provide a cure for vivax malaria.

Although experimentation with primaquine dates back to 1942, it was not until late last year that the Army began routine administration of the drug to all servicemen returning by water from Korea. Used in conjunction with the suppressive drug, chloroquine, primaquine is expected to eliminate malaria as a major military medical problem.

INSECTICIDE DEVELOPMENT

A second significant devolpment was the use of the insecticide, Lindane, to control DDT-resistant Korean body lice. Although DDT is still highly effective against lice in this country and most other areas in the world, it could not halt the stubborn Korean louse.

Developed as a lousicide by the Army Medical Service and the Quartermaster Corps in cooperation with the United States Department of Agrciulture, Lindane ensures the continued freedom of United Nations forces from louseborne epidemic typhus which would be introduced by infested Korean POW's.

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"Premarin" Intravenous is presented in packages providing one "Secule"[R] containing 20 mg. of conjugated estrogens (equine) together with one 5 cc. vial of sterile diluent.

APHORISMS

(Continued from Page 284)

feel my way along, not relying on a mechanical contrivance of that sort. . . . . for routine purposes in younger people, people under 60, the spinous process is probably the site of choice." — B. Jacobson, Medical Grand Rounds, M. G. H., American Practitioner, Oct., '51, Page 888 - 89.

14. "We know that in patients with exophthalmic goitre (primary hyperthyroidism) we can usually bring the metabolism to normal in the number of days that the basal metabolic rate is above normal, and in this group of patients this is quite dependable. In patients with *adenomatous* goitre about twice the number of days is required to bring the basal metabolism to normal, but there are a good many exceptions to this; it often takes three or four times the number of days that the metabolic rate is above normal to bring it to normal in this type of thyroid toxicity." — Frank Lahey, Post-graduate Medicine, May, '51, Page 404.

15. "Everyone who has dealt with hyperthyroidism has known for a long time that two things are true; one is that the patient with severe hyperthyroidism tolerates enormous doses of morphia without respiratory depression and the other is that the patient with hypothyroidism tolerates small doses badly as relates to respiratory depression." — Frank Lahey, loc cit, Page 405.

16. "It should be emphasized that advanced cirrhosis with hepatic insufficiency may be encountered without jaundice. I have repeatedly seen cases of fatal hepatic coma due to cirrhosis, exhibiting Fetor hepaticus and other evidence of failure of liver function, without visible jaundice. This combination has been most common following a sudden large hematemesis. The latter is undoubtedly responsible for further deterioration of liver function, but quite probably also, a throttling of hemoglobin destruction so that bilirubin formation is at a minimum."—Cecil Watson, Minnesota Medicine, Feb., '52, Page 128.

17. "Patients (with cirrhosis) who are able to eat and whose livers are *still enlarged* have by far the best prognosis."—Cecil Watson, loc cit, Page 130.

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